Written Notice of Provider Termination

I am writing to notify the Division of Health Care Financing and Policy (DHCFP) and its Fiscal Agent, HP Enterprise Services, that I wish to terminate my provider enrollment in the Nevada Medicaid and Nevada Check Up programs.

Upon receipt of this form, HP Enterprise Services will update my provider file and my enrollment will be terminated within 90 days. I understand that all outstanding Nevada Medicaid and Nevada Check Up claims must be submitted to HP Enterprise Services within 90 days of the requested date of termination stated below.

This written notice shall be deemed to have been given when sent to the following address by first class United States mail, proper postage prepaid: HP Enterprise Services, Provider Enrollment Unit, PO Box 30042, Reno NV 89520-3042

Within 15 business days of receipt of this form, HP Enterprise Services will mail the provider an acknowledgment of the termination request that includes the official date that the termination will become effective.

Note: *All fields are required. If you have any questions, please call (877) 638-3472.*

PROVIDER INFORMATION
Provider Name:
Business/Facility Address:
NPI/API:
Provider Type and Specialty:
Contact Name:
Contact Phone:
TERMINATION DATE
Requested Date of Termination:
Would you like DHCFP to call you regarding your decision to terminate enrollment? ☐ Yes ☐ No
REASON FOR TERMINATION
☐ Moving/Closing location ☐ Retirement ☐ No longer accepting Medicaid patients ☐ Reimbursement rates ☐ Unresolved claims/billing issues ☐ Other (please explain): _____ _____
ADDITIONAL COMMENTS

Provider Signature: _____ **Date:** _____